DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2020 FORM APPROVED

MAME OF PROVIDER OR SUPPLIER MANDE OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLINE SUMMARY STATEMENT OF DEPICIENCIES 190 SOUTH DIXILE STREET HORSE CAVE, KY 42749	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D/	(X3) DATE SURVEY COMPLETED	
SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated, on 06/03/2020 and concluded on 06/05/2020. The facility was found not in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for			185381	B. WING					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS A COVID-19 Focused Infection Control Survey initiated, on 06/03/2020 and concluded on 06/05/2020. The facility was found not in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WEL				STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET				
A COVID-19 Focused Infection Control Survey initiated, on 06/03/2020 and concluded on 06/05/2020. The facility was found not in compliance with 42 CFR 483.80 infection control regulations and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			X (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR		# D RE	COMPLETION	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focus initiated, on 06/03/2 06/05/2020. The facompliance with 42 regulations and has Medicare & Medica Centers for Disease (CDC) recommend COVID-19. Total ce	sed Infection Control Survey 1020 and concluded on scility was found not in CFR 483.80 infection control simplemented the Centers for id Services (CMS) and e Control and Prevention ed practices to prepare for ensus was 85.		000				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/17/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING _ COMPLETED 185381 B. WING 06/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIGNATURE HEALTHCARE OF HART COUNTY REHAB & WELLNE 1505 SOUTH DIX!E STREET HORSE CAVE, KY 42749 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 000 Initial Comments E 000 A COVID-19 Focused Emergency Preparedness Survey was initiated on 06/03/2020 and concluded on 06/05/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 07/17/2020

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED 100662 B. WING 06/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET SIGNATURE HEALTHCARE OF HART COUNTY HORSE CAVE, KY 42749 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated 06/03/2020 and concluded on 06/05/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

I8LL11